| CENTERS FOR MEDICARE & MEDICA | AID SERVICES | | OMB NO. 0938-0391 |
|-------------------------------|----------------------------|----------------------------|-------------------|
| STATEMENT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY |
| AND PLAN OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING 00 | COMPLETED |
| | 155332 | D. WING | 07/01/2011 |

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

| HERITA | GE HOUSE REHABILITATION & HEALTHCARE CENT | I | CO RD 200 E ERSVILLE, IN47331 | |
|--------------------------|---|---------------------|--|----------------------------|
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| TAG F0000 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00092575. Complaint IN00092575 Substantiated. No deficiencies related to the allegations are cited. Survey dates: June 27, 28, 29, 30, July 1, 2011 Facility number: 000225 Provider number: 155332 AIM number: 100267670 Survey team: Angel Tomlinson RN TC Sharon Lasher RN June 27, 28, 30, July 1, 2011 Barbara Gray RN June 28, 29, 30, July 1, 2011 Census bed type: SNF/NF: 90 Total: 90 Census payor type: Medicare: 12 Medicaid: 56 Other: 22 Total: 90 | F0000 | The creation and submission of this plan of corrrection does not constitute an admision by this provider or any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a post certification review on or after 7/22/11. We are requesting a desk review. | DATE |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Event ID:

4ZWO11

Facility ID:

000225

TITLE

If continuation sheet

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155332 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 07/01/2011 | | |
|--|--|---|----------|---|--|---|----------------------------|
| NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE REHABILITATION & HEALTHCARE CEN | | | STREET A | DDRESS, CITY, STATE, ZIP CODE O RD 200 E RSVILLE, IN47331 | 1 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ιΤΕ | (X5) COMPLETION DATE |
| | Sample: 17 These deficiencies findings in accordance with plan of care. Based on observative record review, the staff on the use of according to the 1 of 2 residents of transfers, in the staff on the use of according to the 1 of 2 residents of transfers, in the staff on the use of according to the 1 of 2 residents of transfers, in the staff on the use of according to the 1 of 2 residents of transfers, in the staff on the use of according to the 1 of 2 residents of transfers, in the staff on the use of according to the 1 of 2 residents of transfers, and the staff on 6/29/11 at 8:4 included but wer Parkinson's, and An admission Massessment dated Resident #81 had impairment, requirement, | es also reflect State dance with 410 IAC 16.2. completed 7/5/11 RN ded or arranged by the ovided by qualified persons a each resident's written ation, interview, and a facility failed to train of an Invacare lift operating instructions for observed for Invacare sample of 17. (Resident 's record was reviewed 5 A.M. Diagnoses e not limited to anxiety, severe osteoarthritis. inimum Data Set 1 5/28/11, indicated I lower extremity sired total dependence of I mobility and transfers, | FO | | CROSS-REFERENCED TO THE APPROPRIA | Il be dents by ag the vith and Only is other al to icient dents hat ace or will | |

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Event ID:

4ZWO11 Facility ID:

000225

If continuation sheet

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| | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|-----------|--|--|--------|----------|---|---|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPL | |
| | | 155332 | B. WIN | | | 07/01/2 | 011 |
| NAME OF I | DROVIDED OD GUDDI IED | | - | STREET A | ADDRESS, CITY, STATE, ZIP CODE | ! | |
| NAME OF I | PROVIDER OR SUPPLIER | | | 281 S C | O RD 200 E | | |
| | | ILITATION & HEALTHCARE CEN | TER | | ERSVILLE, IN47331 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | + | TAG | , | | DATE |
| TAG | Resident #81 was transferred from chair on 6/28/11 assistance of CN an Invacare lift. Invacare legs und position. The Invacare legs under the lift and Re his air mattress. the Invacare lift a QMA #2 informed lift legs. CNA #1 legs under the be CNA #1 indicate residents from the in the closed posteristents had a both that prevented the Resident #81 was transferred from bed on 6/30/11 at assistance of CN an Invacare lift. Invacare lift legs around Resident Invacare sling was CNA#4 locked be CNA #4 lifted Removed the geriat from the lift. CN | his bed to a geriatric at 3:10 P.M., with the A #1 and QMA #2, using CNA #1 positioned the der the bed in the closed vacare sling was attached sident #81 was lifted off CNA #1 started to pull away from the bed and ed CNA #1 to open the 1 opened the Invacare lift d without difficulty. d she normally lifted eir bed with the lift legs ition because some ar underneath their bed e legs from opening. s observed being his geriatric chair to his t 3:05 P.M., with the A #3 and CNA #4, using CNA #4 spread the in the opened position #81's geriatric chair. The as attached to the lift and oth rear wheel casters. esident #81, then CNA #3 ric chair backwards away IA #4 unlocked both rear | | TAG | practice does not recur?Policy/procedure and validation checklist were rev to meet manufaturer's guide and to match each other to indicate caster not to be lock All new nursing staff will be in-serviced during orientation Care plan/assessment shee have been updated. How will corrective action(s) be monit to ensure the deficient practi will not recure, i.e. what qua assurance program will be p into place?QA&A will monitodays per week for 1 month; days per week for 1 month; days per week for 1 month; monthly for the next 6 month and then will be evaluated by QA&A members. Using 10% the population and different shifts. ASC/designee will monitor. Deadline is 7/2/11 | ised lines red. n. ts the cored fice lity ut r 5 3 2 then ns y | DATE |
| | | d maneuvered Resident mattress. Resident #81 | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|----------------------|-------------------------------|--------------------|--------|--|-------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPI | LETED |
| | | 155332 | B. WING 07/01/2011 | | | | |
| | | l . | B. WIIV | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF 1 | PROVIDER OR SUPPLIEF | 8 | | 1 | CO RD 200 E | | |
| HERITA | GE HOUSE REHAB | ILITATION & HEALTHCARE CEN | TER | 1 | ERSVILLE, IN47331 | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | ICY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI | ATE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | was lowered ont | o his mattress. An | | | | | |
| | interview with C | CNA #4 indicated she | | | | | |
| | always locked th | ne Invacare lift rear casters | | | | | |
| | when she lifted a | a resident. CNA #4 | | | | | |
| | indicated she wa | s trained to lock the rear | | | | | |
| | wheel casters be | fore lifting a resident. An | | | | | |
| | | NA #3 indicated she | | | | | |
| | | ne Invacare lift rear casters | | | | | |
| | 1 - | a resident. CNA #3 | | | | | |
| | | is trained to lock the rear | | | | | |
| | | | | | | | |
| | wheel casters be | fore lifting a resident. | | | | | |
| | An interview wi | th the Staff Development | | | | | |
| | | _ | | | | | |
| | | 6/30/11 at 3:35 P.M., | | | | | |
| | | ined staff to operate the | | | | | |
| | | n the legs in the opened | | | | | |
| | 1 ^ | the rear wheel casters of | | | | | |
| | | pefore lifting a resident. | | | | | |
| | The Staff Develo | opment Coordinator | | | | | |
| | indicated the fac | ility policy stated to lock | | | | | |
| | the rear wheel ca | asters of the Invacare lift | | | | | |
| | before lifting a r | esident. | | | | | |
| |] | | | | | | |
| | The most curren | t Mechanical lift | | | | | |
| | procedure provid | ded by the Staff | | | | | |
| | | oordinator on 6/30/11 at | | | | | |
| | | ated the following. | | | | | |
| | 1 | so that legs are under | | | | | |
| | bed/lock wheels | | | | | | |
| | JUCATOCK WILCES | •••• | | | | | |
| | The most curren | t Mechanical lift policy | | | | | |
| | | Director of Nursing on | | | | | |
| | | _ | | | | | |
| | | A.M., indicated the | | | | | |
| | tollowing:13 |). "Begin lifting per | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY COMPLETED | | |
|--|---|--|----------------------------|-------------|--|-------------------------------|------------|--|
| AND PLAN | OF CORRECTION | 155332 | 1 | BUILDING 00 | | | 07/01/2011 | |
| | | 100002 | B. WIN | | DDDEGG GITY GTATE ZID CODE | 0770172 | 011 | |
| NAME OF P | PROVIDER OR SUPPLIER | | | 1 | DDRESS, CITY, STATE, ZIP CODE | | | |
| HERITAG | SE HOUSE REHABI | LITATION & HEALTHCARE CEN | TER | 1 | RSVILLE, IN47331 | | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | * | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | E | COMPLETION | |
| TAG | | LSC IDENTIFYING INFORMATION) | + | TAG | DEFICIENCY) | | DATE | |
| | manufactures ins | tructions" | | | | | | |
| | by the Staff Deve 6/30/11 at 3:48 P following: Warn lift with the legs position and lock legs must be lock at all times for sta when lifting and Invacare does no the rear casters o lifting an individ- cause the lift to the patient and assist recommend that unlocked during allow the patient | eration manual provided elopment Coordinator on .M., indicated the ing - Only operate this in maximum open red in place. The base red in the open position ability and patient safety transferring a patient. It recommend locking of the patient lift when real. Doing so could ap and endanger the ants. Invacare does the rear casters be left lifting procedures to lift to stabilize itself is initially lifted from a stationary object. | | | | | | |
| F0323 SS=D | environment rema hazards as is poss receives adequate devices to prevent Based on observa | nsure that the resident ins as free of accident sible; and each resident supervision and assistance accidents. ation, interview, and e facility failed to follow | FO | 0323 | What corrective action(s) will accomplished for those resid | | 07/22/2011 | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|---|------------------------------|----------------------------|----------|--|------------------|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | ILDING | 00 | COMPL | | |
| | 155332 | | B. WIN | NG | | 07/01/2 | 011 | |
| NAME OF | PROVIDER OR SUPPLIEI | 3 | • | STREET A | ADDRESS, CITY, STATE, ZIP CODE | • | | |
| | | | | | CO RD 200 E | | | |
| HERITA | GE HOUSE REHAB | SILITATION & HEALTHCARE CEI | NTER | CONNE | ERSVILLE, IN47331 | | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | (EACH DEFICIENCY MUST BE PERCEDED BY FULL | | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION | |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE | |
| | 1 | ating instructions for | | | found to have been affected the deficient practice?Nursin | • | | |
| | 1 | sident with an Invacare | | | staff has been trained on | 9 | | |
| | lift, for 2 resider | nts observed for Invacare | | | transferring Resident #81 wi | th | | |
| | transfers, in the | sample of 17. (Resident | | | Invacare Lift using | | | |
| | #81) | | | | manufacturing's guidelines v | vith | | |
| | | | | | return demonstration. SDC | | | |
| | Findings include | e: | | | in-serviced staff on 7/5, 7/7 and 7/8/11 on how to use the lift. | | | |
| | | | | | Invacare Lifts are used in thi | • | | |
| | 1.) Resident #8 | l's record was reviewed | | | facility. How will you identify | | | |
| | 1 1 | 45 A.M. Diagnoses | | | residents having the potentia | | | |
| | | re not limited to anxiety, | | | be affected by the same defi | | | |
| | | severe osteoarthritis. | | | practice and what corrective | | | |
| | arkinson s, and | severe osteoartimitis. | | | action will be taken?All resid reviewed using care | enis | | |
| | An admission M | Iinimum Data Set | | | plans/assessment sheets to | | | |
| | | | | | indicate if Invacare Lift is bei | ng | | |
| | | d 5/28/11, indicated | | | used. Nursing staff has bee | | | |
| | | d lower extremity | | | trained on transferring Resid | ents | | |
| | | uired total dependence of | | | with Invacare Lift using manufacture's guidelines.Wh | nat | | |
| | 1 ^ | d mobility and transfers, | | | measures will be put into pla | | | |
| | and did not walk | ζ. | | | what systemic changes you | | | |
| | | | | | make to ensure that the defi | cient | | |
| | | s observed being | | | practice does not | | | |
| | transferred from | his bed to a geriatric | | | recur?Policy/procedure and validation checklist were rev | isod | | |
| | chair on 6/28/11 | at 3:10 P.M., with the | | | to meet manufcturer's guidel | | | |
| | assistance of CN | IA #1 and QMA #2, using | | | and to match each other to | | | |
| | an Invacare lift. | CNA #1 positioned the | | | indicate caster not to be loce | ed. | | |
| | Invacare legs un | der the bed in the closed | | | All new nursing staff will be | | | |
| | position. The Invacare sling was attached | | | | in-serviced during orientation | | | |
| | 1 ~ | esident #81 was lifted off | | | Care plan/assessment shee have been updated.Please r | | | |
| | his air mattress. | CNA #1 started to pull | | | that here has not been any | | | |
| | | away from the bed and | | | incidents/accidents with the | | | |
| | | ed CNA #1 to open the | | | Invacare Lift.How will the | _ | | |
| | , | 1 opened the Invacare lift | | | corrective action(s) be monit | | | |
| | _ | ed without difficulty. | | | to ensure the deficient practi will not recur, i.e., what quali | | | |
| | | ed she normally lifted | | | assurance program will be p | | | |
| | CINA#1 Illuicate | a she normany lineu | | | | | | |

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Event ID: 4ZWO11 Facility ID: 000225

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|---|---|--|------------|------------|--|--------------|--|
| AND PLAIN | OF CORRECTION | 155332 | - 1 | LDING | 00 | 07/01/2011 | |
| | | 100002 | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | 0770 1720 11 | |
| NAME OF PROVIDER OR SUPPLIER | | | | | O RD 200 E | | |
| HERITA | GE HOUSE REHAB | ILITATION & HEALTHCARE CE | NTER | 1 | ERSVILLE, IN47331 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | ` | ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION) | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | | |
| TAG | • | | | TAG | into place?QA&A will monito | DATE | |
| | | neir bed with the lift legs | | | days per week for 1 month; | | |
| | 1 | sition because some par underneath their bed | | | days per week for 1 month; 2 | 2 | |
| | | ne legs from opening. | | | days per week for 1 month; t | | |
| | linat prevented th | ie legs from opening. | | | monthly for the next 6 month Using 10% of the population | I | |
| | Resident #81 wa | s observed being | | | different shifts. SDC/design | ee | |
| | | his geriatric chair to his | | | will monitor. Deadline is 7/2 | 2/11 | |
| | | at 3:05 P.M., with the | | | | | |
| | | IA #3 and CNA #4, using | | | | | |
| | | CNA #4 spread the | | | | | |
| | | s in the opened position | | | | | |
| | _ | #81's geriatric chair. The | | | | | |
| | Invacare sling was attached to the lift and | | | | | | |
| | CNA#4 locked b | ooth rear wheel casters. | | | | | |
| | CNA #4 lifted R | esident #81, then CNA #3 | | | | | |
| | moved the geria | tric chair backwards away | | | | | |
| | from the lift. CN | NA #4 unlocked both rear | | | | | |
| | | d maneuvered Resident | | | | | |
| | | mattress. Resident #81 | | | | | |
| | | o his mattress. An | | | | | |
| | | NA #4 indicated she | | | | | |
| | 1 | ne Invacare lift rear casters | | | | | |
| | | a resident. CNA #4 | | | | | |
| | | s trained to lock the rear | | | | | |
| | 1 | fore lifting a resident. An | | | | | |
| | | NA #3 indicated she | | | | | |
| | 1 1 | ne Invacare lift rear casters a resident. CNA #3 | | | | | |
| | | is trained to lock the rear | | | | | |
| | | fore lifting a resident. | | | | | |
| | which casters be | iore munig a resident. | | | | | |
| | The most curren | t Mechanical lift policy | | | | | |
| | provided by the | Director of Nursing on | | | | | |
| | 7/1/11 at 11:48 A | A.M., indicated the | | | | | |

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Event ID: 4ZWO11 Facility ID: 000225

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155332 | | A. BUI | LDING | NSTRUCTION 00 | COMI | (X3) DATE SURVEY COMPLETED 07/01/2011 | |
|--|---|--|--------|---------------|---|---------------------------------------|----------------------|
| NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE REHABILITATION & HEALTHCARE CE | | | | STREET A | DDRESS, CITY, STATE, ZIP CODE O RD 200 E RSVILLE, IN47331 | | |
| | SUMMARY S (EACH DEFICIENT REGULATORY OR following:13) manufactures ins The Invacare ope by the Staff Deve 6/30/11 at 3:48 P following: Warn lift with the legs position and lock legs must be lock at all times for st when lifting and Invacare does no the rear casters o lifting an individ cause the lift to to patient and assist recommend that unlocked during allow the patient when the patient | TATION & HEALTHCARE CENT TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) . "Begin lifting per | B. WIN | STREET A | O RD 200 E | ION D BE | (X5) COMPLETION DATE |
| | | | | | | | |